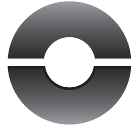

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, ______________________________________ give permission to Valley Eye Associates,
(please print patient name)
allowing them to speak with the person/people listed below regarding any information related to my appointments, billing information or health care. I understand that this authorization will remain in effect until I choose to revoke it.

NAME	RELATIONSHIP TO PATIENT

______________________________________ ______________________
Signature of patient or personal representative Date

____
If personal representative, describe relationship

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719 Doctors Court • Oshkosh, WI 54901 • Phone 920-235-0066 • Fax 920-235-5596